EXPRESSIVE SPEECH & FEEDING

Payment Policy & Fee Schedule

Please know that the timely payment of your bill is an integral part of our service and as such, this payment policy is an agreement between you and Expressive Speech and Feeding, LLC for payment of services provided. By signing this policy, you are agreeing to pay for services provided to you or your family member. As a client Expressive Speech and Feeding, LLC you must carefully review and sign our payment policy.

Monthly invoices are sent on the last business day of the month. Monthly invoices will be automatically charged to the credit card on file. If we are unable to charge the credit card on file within 7 days of the invoice date, a 10% late fee will be assessed and a second invoice will be issued. An additional 5% late fee will be added for every additional 7 days an invoice is overdue. If invoices are unpaid after 30 days (from the date of posting of the invoice), services will be suspended and accounts turned over to a collections agency.

Speech-Language evaluation and report	$220
Feeding evaluation and report	$220
Speech **and** Feeding evaluation and report	$350
Infant Feeding Evaluation and report (for babies exclusively bottle / breast fed)	$160
Individual speech-language or feeding therapy	$110 / hour
Group therapy (social, feeding, Mom & Tots)	$100/month
Consultative Services/IEP Advisory	$110 / hour

We accept only credit card payment via Square. We require all clients to keep a current credit or debit card and authorization on file. We will provide you an invoice and superbill (if requested) outlining services rendered and amount charged.

Please read and check all boxes to acknowledge understanding and agreement and then sign below:

☐ I understand that health insurance policies and reimbursement are between myself and my health insurance company, that all services rendered by Expressive Speech and Feeding, LLC for the benefit of the above referenced individual are charged directly to me, and I am personally responsible for payment in full to Expressive Speech and Feeding, LLC. I also understand Expressive Speech and Feeding, LLC won't become involved in disputes between me and a third-party source regarding uncovered charges or reasons for denial.

☐ I understand if fees are not paid in full, treatment sessions may be cancelled until payment is received.

☐ I understand that I am responsible for all legal and collection fees, which Expressive Speech and Feeding, LLC may incur if payment is not made in accordance with the terms and conditions herein.

☐ I, _____, (client / guardian name) understand the payment policy and the risks of not adhering to it.

_____ _____

Print Name of Client | Date of Birth

_____ _____ _____

Signature of Client, Guardian or Responsible Party | Relationship to Client

_____ _____

Private Practitioner / Witness | Date

Payment Policy & Fee Schedule (Effective 1/7/2021)